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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CHAD JOSEF MEDLIN a.k.a., JOE HALL CUNNINGHAM, JR. 2419 Pima Lane Ventura, CA 93001 Registered Nurse License No. 277381 Respondent.	Case No. 2008-153 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H, R.N (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about March 31, 1977, the Board issued Registered Nurse License No. 277381 to Chad Josef Medlin, also known as Joe Hall Cunningham, Jr. (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2008, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or regulations adopted pursuant to it."

7. California Code of Regulations, title 16, section 1442 states:

"As used in Section 2761 of the Code, 'gross negligence' includes an extreme departure from the standard of care, which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the failure to

provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation in which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443 states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

10. California Code of Regulations, title 16, section 1444 states:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare."

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

Patient J. A.

12. Patient J.A. was a 20 year old male resident of Care Meridian, a subacute care, rehabilitation facility located in Oxnard, California. He was admitted in a comatose state after he had sustained an anoxic brain injury during a surfing accident on October 20, 2003. On May 28, 2004, the supervising physician at Care Meridian inserted a gastrostomy tube and prescribed scheduled feedings and hydration through the tube for J.A.

13. On June 2, 2004, at approximately 3:00 a.m., J.A.'s gastrostomy tube became dislodged and it was re-inserted by the LVN on duty. The gastrostomy tube was incorrectly placed in the abdominal cavity rather than inside the stomach. Approximately 12 hours later, J.A. died from peritonitis caused by the introduction of food directly into the abdominal cavity through the feeding tube.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

14. Respondent's license is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, as defined in California Code of Regulations, title 16, section 1442, in that Respondent, while employed as the Director of Nurses at Care Meridian, was grossly negligent in his care of patient J.A., as follows:

15. Respondent failed to intervene on June 2, 2004 when he was first advised by the Care Meridian staff that J.A.'s condition was deteriorating as follows:

A. On June 2, 2004, at approximately 11:30 a.m., Patricia R., the LVN on duty, notified Respondent of J.A.'s physical condition in that he continued to sweat, had pale color, moist skin and open eyes. Respondent advised the LVN that he believed that the symptoms indicated that J.A. was "catching a cold." Respondent did not make an independent assessment of J.A.'s condition, nor give the LVN any further instructions for client care.

B. At approximately 2:15 p.m., Patricia R. contacted the physician's office. Respondent was present at J.A.'s bedside and also spoke with the physician's office. Respondent instructed Patricia R. to arrange for an ambulance to transport J.A. to the hospital. J.A. was pronounced dead on arrival at the hospital at 3:30 p.m..

16. Respondent failed to have in place a written policy and procedure for Care Meridian staff involving gastrostomy tubes as follows:

A. Respondent failed to have in place a written policy and procedure for staff to use when checking for the correct placement of gastrostomy tubes prior to feeds, hydration and medication administration.

B. Respondent failed to have in place a written policy and procedure to direct nursing staff to notify the physician if a gastrostomy tube becomes dislodged.

17. Respondent failed to ensure that all Care Meridian staff had received training on current policy and procedures for caring for clients with gastrostomy tubes.

18. Respondent failed to ensure that all Care Meridian staff was competent in caring for clients with gastrostomy tubes.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent's license is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, as defined in California Code of Regulations, title 16, sections 1443 and 1443.5 in that Respondent, a registered nurse, demonstrated incompetence, in his care of patient J.A. by the conduct described above in paragraphs 15 through 18 above, and incorporated herein by this reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

20. Respondent's license is subject to disciplinary action under section 2761, subdivision (a) and (d), on the grounds of unprofessional conduct, as defined in California Code of Regulations, title 16, section 1444, in that Respondent evidenced the present or potential unfitness to practice in a manner consistent with the public health, safety, or welfare by his actions or conduct, in caring for patient J.D., as more fully set forth above in paragraphs 15 through 18 above, and incorporated herein by this reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License No. 277381, issued to Chad Josef Medlin, also known as Joe Hall Cunningham, Jr.;

2. Ordering Chad Josef Medlin, also known as Joe Hall Cunningham, Jr. to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 11/9/07

RUTH ANN TERRY, M.P.H, R.N
Executive Officer
Board of Registered Nursing
State of California
Complainant

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